Comments from David Pyle, Interim CEO
Managed HealthCare Northwest, Inc.
Submitted on 9/15/2022

Theresa's (somewhat) organized notes – Worker Continuation of Care Subcommittee, 8/25/2022
(to be considered as a working draft – meeting audio available at https://youtu.be/854MCirqobg)

Mentioned ideas + thoughts

Specific to workers

- Critical need for workers to stay in contact with their providers and continue to receive treatment. Establishing a requirement for such not currently enforceable by statute.
- Workers who do not follow prerequisites for treatment. Example from a claim: worker who needed to quit smoking and lose weight before surgery, did not return for treatment nine months later.
    - One perspective: Few options for contacting the worker.
        - A bug letter to the worker was not appropriate – the doctor didn't need to see the worker until the requirements were met.

Our MCO does receive concerns from insurers when workers are not following up with recommended treatment, either with returning to physician offices for assessments or scheduling visits with other providers, such as scheduling imaging or physical therapy treatment. In those cases, we contact the attending physician to confirm the treatment recommended and obtain permission to facilitate the treatment. We then will either schedule the treatment for the worker or attempt to contact the worker/representative by phone to discuss the need for follow-up and offer to schedule the treatment for the worker. If the worker does not return our calls or does not schedule the treatment after agreeing to do so, we then schedule the treatment for the worker and send the worker a notification of the appointment(s). The insurer then has the option of making the visit mandatory as allowed by OARs. Of note, MCOS are not permitted to make visits mandatory.

        - Options – a notice to the worker asking for the prerequisites to be met or contacting the worker's representative for a status update.
    - Counterpoint: The worker did not receive instructions for post-appointment engagement by the physician or their employer.

There is an ORS regarding injurious practices: 656.325(2): For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal.

If the physician considers the worker's actions to be insanitary or injurious per the state definition and documents that opinion, the insurer can request benefit suspension. However, since the worker has the right to refuse treatment, the physicians would need to be very clear concerning the education/counsel provided to the worker and the worker's response to the education/counsel. Of note: As with mandatory visits, MCOs are not permitted to make any decision/request regarding suspending benefits. The process is only afforded to insurers.

- Real life obstacles that prevent workers from obtaining treatment. Examples:
    - Treatment schedule had to be adjusted based on employer feedback and scheduling;

    - Long wait periods for receiving treatment due to the provider's office being booked out for weeks/months;
    - Disparities for non-English speaking workers and those without access to telemedicine; and
    - Limited child care.
- Current wage replacement rate vs. full wage replacement.
    - The burden that the 2/3 wage rate places on minimum wage and other workers.
    - Injured worker may not be able to afford taking time off to seek treatment.

Specific to employers/insurers

- Workers being refused treatment due to a tight turnaround time for compensable claims.
- Identified tools in communicating with workers are either ineffective or place undue burden on workers.
    - Option of cutting off benefits to workers who do not schedule/attend a follow up appointment does not currently exist. **See above**
    - Idea of cutting off payments to providers under any circumstance could mean that more providers are unwilling to treat injured workers.
    - Closing a claim administratively when the worker is not medically stationary creates burdens to the worker.

Specific to providers

- Lack of requirements for all attending physicians to see a worker on a timely basis. MCOs have requirements for seeing a worker every 30 days.

This is not a universal MCO rule. Our MCO requires provision of medically appropriate treatment and that would include a visit frequency considered reasonable based on the acuity of the worker's condition and amount of oversight needed. As an example, a worker who is currently healing from an uncomplicated bone fracture and being seen regularly by PT would not necessarily need to be seen every 30 days. However, a worker with increasing symptoms following a complex injury and not receiving treatment from any other medical professional may need to be seen more frequently than every 30 days.

Our MCO does require physicians to adhere to OARs but this is also not an OAR requirement. The rules do not address physician visit frequency. They do state that the insurer may require a progress report from the attending physician every 14 days when a worker is not released to full work duties, but the rule does not require that a visit be provided with each progress report.

As an MCO, we do have a concern with attempting to require physicians to see all workers every 30 days. As noted in your discussion, there are many barriers to accomplishing this that include physician availability and staffing shortages in many physician offices. Additionally, there may be delays in the worker accessing other treatment such as imaging and/or therapy. A follow-up visits with the physician may not be considered reasonable until the ordered treatment has been done. We are concerned that adding this requirement rather than relying on the physician's judgement regarding the visit frequency would prove frustrating for physicians and deter physicians from accepting injured workers.

- Feasibility of allowing other practitioners to provide input and updates to alleviate scheduling constraints with the attending physician versus broadening the pool of providers.
- Not enough providers.
- Confusion around workers not being able to see a provider in a timely fashion.

- Gap around providers wanting to release workers without seeing them.

General

- Who should have the burden for remedying a communication breakdown between physician and insurance provider. Should there be a clearer expectation on how to handle claims such as this?
- Creating a hard time limit of 30 days for treatment would be no different than any other timeline-dependent treatment.
- Incentivizing compliance has better performance outcomes than punitive measures.
- Context of using "provider" in subcommittee discussions: all who provide treatment to injured workers, not just the attending physician.
- If the current tools in place for continuity of care are or are not working.

Requests from MLAC members:

- What other states are doing to address issues raised during subcommittee discussions.
- Perspectives from MCOs, providers and workers about their perspective on this issue.

Our MCO, as required by OARs, routinely addresses continuity of care for our enrolled workers. To that end, we approve treatment with non-contracted providers to facilitate worker access to treatment by physicians having a pre-existing relationship with the worker. If a worker requests that we approve treatment by a non-contracted physician and the physician has treated the worker prior to the work injury, or even if the worker had been seeing other physicians at that clinic, the MCO will consider the physician to meet the state's definition of a PCP and approve treatment with the physician. Additionally, if the worker underwent surgery performed by a non-contracted surgeon prior to enrollment into the MCO and additional surgery is needed, our MCO will approve ongoing treatment with the surgeon if the additional surgery involves the same diagnosis or if the complexity of the worker's condition indicates potential for adverse effects if the worker were to change to a new provider. We will also consider approving treatment with other non-contracted providers, such as non-PCP physicians/Physician Assistants/Nurse Practitioners/Physical Therapists/et. al. if it appears the worker's progress would be negatively impacted by the need to change to a contracted provider.

- Thoughts from and/or interactions with the Workers' Compensation Division's Medical Advisory Committee (MAC).
    - Stakeholders presented the topic to this committee in May 2022.
    - The meeting minutes are an exhibit for the upcoming subcommittee meeting, available at 5-21-21 MAC final minutes.pdf (oregon.gov) (pages 4-5).
- Interaction with MCO RN care managers – what the process looks like on their end.

Our MCO RN case managers review all requests for treatment with non-contracted providers and approve the treatment if the above criteria are met. If it appears the criteria are not met, the request is forwarded to one of the MCO physicians for further review. The physician is the only individual permitted to decide that the request is not to be approved.

Our MCO also attempts to proactively identify when a continuity of care issue is present. If we are notified by either the worker, the claims adjuster or by another medical provider that the worker needs assistance with accessing a physician, we discuss the treatment received to date to determine if there is a continuity of care issue present. We may then reach out to the worker to discuss the worker's medical need and his/her preference for the treating

provider. If there is a continuity of care issue present, we offer to contact the previously/currently treating provider to facilitate ongoing treatment with the provider, if possible. The obstacles we face in accomplishing this is primarily due to the providers' preferences. Some providers do not wish to continue to treat work injuries or work with an MCO. Other providers are not permitted to treat work injuries by their clinic policies.

- Estimation of number of bug letters sent to injured workers due to nonengagement, and responses to those letters.

One final thought. There was a mention of using alternative providers to augment the care for workers and so increase medical oversight. We would encourage you to obtain input from other providers regarding this. For example, if the thought was to expand the attending physician status of Physician Assistants beyond the current 60-day period, we feel it important to seek input from MD/DO/DC providers since Physician Assistants require physician oversight and this may place an added burden on the physicians.